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ABSTRACT

In Australia, drug and alcohol education should be an integral part of a total health education program with an emphasis on developing student decision-making powers. The use of explicit information about drugs and attempts to scare people away from drugs may actually be counterproductive and encourage drug abuse. The teacher is the primary health educator in the school, and speakers on health from outside the school must be used in moderation. There are a number of shortcomings in the current provision of drug and health education. There must be stronger support for health education, commencing in the primary school. A number of agencies are available for drug education and counselling. Greater coordination of all agencies is called for. There should be more opportunities for continuing education for health teachers. Many groups in the community can benefit from health education programs. The mass media may at times inadvertantly encourage drug use and ought to be more responsible. Legislators ought to keep an open mind about the desirability of legal sanctions against drug use. Related materials in the appendix include surveys of student drug use, a proposed drug education program, and a recommendation for the principal's response to drug abuse in the school. (Author/JM)

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ED165229

EDUCATION AND DRUGS

Report of the Education Sub-Committee of the Alcohol and Drug Authority

DECEMBER
1976

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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EDUCATION DEPARTMENT, WESTERN AUSTRALIA

EA 011 085

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LETTER OF TRANSMITTAL

2nd December, 1976

Rev. G Smith,
Chairman,
Advisory Council to the Western Australian
Alcohol and Drug Authority,
Charob House,
25 Richardson Street
WEST PERTH W A 6005

Dear Mr Smith,

I am pleased to present to you the Report of the Education Sub-Committee of the Alcohol and Drug Authority.

The Sub-Committee was formed at the suggestion of your Council in order to provide feedback to the Alcohol and Drug Authority from the education community.

There was from the outset a large degree of flexibility as to how this and similar sub-committees would function; but the Education Sub-Committee felt that it could make the greatest contribution by producing a written report on matters of drug taking which it considered to be the most pressing in the educational context. In a section on proposed administrative arrangements, this Report suggests how further involvement in the education field should take place.

The Sub-Committee held five full meetings and established working parties which utilized the expertise of a number of other people. In addition the Secretary was able to undertake a short study tour in other parts of Australia to interview experts in the fields of drug education and treatment.

I wish to express my gratitude to all members of the Sub-Committee for the spirit of enthusiasm, industriousness and cooperation to which they contributed. Special thanks are due to the Education Department of Western Australia. Without the Department's generous provision of personnel and other support, the preparation of a Report of this dimension would not have been possible. My sincerest thanks go to the Secretary of the Sub-Committee, Mr Michael Helm, for the time and care he has given in composing and compiling the Report.

Yours sincerely,

C. G. Fitzpatrick.

(C G FITZPATRICK)
CHAIRMAN

MEMBERS OF THE SUB-COMMITTEE

Mr Cliff Fitzpatrick (Chairman)	Assistant Director of Planning, Education Department of W.A.
Mr John Bennett	Senior Master, Biological Sciences, Kent Street Senior High School.
Mr Jim Carr	Executive Officer, Health Education Council of W.A.
Dr Judith Henzell	Senior Medical Officer (School Health), Community and Child Health Services, Department of Public Health.
Mr George Hunt	Principal, Kalamunda Primary School.
Mr John Inglis	Assistant Director of Schools (Primary), Education Department of W.A.
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Mr Roy Nathan	Acting Education Officer, Curriculum Branch, Education Department of W.A.
Mr Jerry von Bamberger	Acting Senior Education Officer (Psychological Services), Guidance Branch, Education Department of W.A.
Mr Ray Ware	Principal, Counselling Service, Education Department of W.A.
Mr Glynn Watkins	Principal-designate, Wanneroo High School.
Mr Barry Wells	Acting Superintendent of Education, Education Department of W.A.
Mr Mike Helm (Secretary)	Education Officer, Administrative Research Branch, Education Department of W.A.

The following have deputized at Committee meetings :

Mr Vic Cooper	Education Officer, Counselling Service, Education Department of W.A.
Mr Ken Hill	Acting Education Officer, Curriculum Branch, Education Department of W.A.
Mrs Ruth Watson	Health Education Officer, Health Education Council of W.A.

SUMMARY AND RECOMMENDATIONS

The health of the student has always been a major objective of the education system. Although the effectiveness of the school in this area is limited, society is turning to educational institutions to help to cope with the problem of drug abuse. There is a drug problem in Australian schools but it should not be blown out of proportion. Some of the major areas of concern are those which are in general socially acceptable, viz. consumption of alcohol and minor analgesics, and cigarette smoking.

A number of schools are attempting drug education programmes but there are dangers associated with some approaches. Chapter 1 sets out the desirable principles for such involvement by schools. In brief, the Sub-Committee believes that drug education should be an integrated part of a total health education programme with an emphasis on developing decision making powers in students. The use of explicit information about drugs, and attempts to scare people away from drugs may actually be counter-productive and encourage drug abuse. The teacher is the primary health educator in the school, and speakers on matters such as drugs from outside the school must be used with discretion.

Chapter 2 refers to current provision of drug and health education, and the Sub-Committee has found that a number of shortcomings currently exist. The Sub-Committee wants to see stronger support for health education, commencing at the primary school level. This Chapter provides a list of agencies from outside the school which are available for drug education and counselling. Greater co-ordination of all agencies is called for.

Chapter 3 reviews education available for health teachers and calls for more opportunities for continuing development of these teachers. A large number of other groups in the community are seen as desirable targets for health education programmes. The Sub-Committee expresses misgivings about the role of the mass media which may at times be inadvertently encouraging drug use; and seeks a more responsible approach by the media. Certain administrative arrangements are then suggested in order to develop a positive health programme. The Sub-Committee requests that legislators keep an open mind about the desirability of legal sanctions against drug abuse.

Appendix 4 is a proposed memorandum to school principals giving guidance as to desirable courses of action to take if drug involvement at a school is detected.

The Sub-Committee's recommendations are as follows:

RECOMMENDATION 1 (page 9)

School education programmes relating to the use of drugs should be conducted in accordance with the principles espoused in Chapter 1.

RECOMMENDATION 2 (page 14)

That a strong health education programme with emphasis on the early primary level be mounted within the Education Department of Western Australia, supported by an administrative structure which is able to provide effective backing to such a programme.

RECOMMENDATION 3 (page 21)

That the Education Department of Western Australia, the Catholic Education Commission and other non-government schools give consideration to endorsing and circulating the proposed memorandum to school principals which is contained in Appendix 4.

RECOMMENDATION 4 (page 25)

The Sub-Committee recommends that further opportunities be made available for the continuing education of teachers of health education in both government and non-government schools.

RECOMMENDATION 5 (page 28)

That the Sub-Committee confer with the Private Sector Sub-Committee of the Alcohol and Drug Authority with a view to devising means for encouraging a positive health message in the mass media.

RECOMMENDATION 6 (page 29)

That the administrative arrangements proposed in sub-sections 1 to 4 of Section 3.06 be implemented.

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INTRODUCTION

0.01 BACKGROUND TO THE SUB-COMMITTEE

The Alcohol and Drug Authority Act, 1974 was established for the purpose of constituting a body corporate with the functions of providing treatment, management, care and rehabilitation of persons suffering from the consumption of alcohol or intoxicating liquors or drugs to excess. It was also introduced to subsidise research and educational facilities directed at prevention and treatment of alcohol and drug abuse and with other functions related thereto.

The inaugural meeting of the Advisory Council to the Authority was held in August 1975. The Council was seen as a means of providing the Authority with feedback from the community. At this meeting members were asked if they would form committees covering their own field of expertise. Mr C G Fitzpatrick, Assistant Director of Planning of the Education Department of Western Australia, represented the Education Department at the inaugural meeting. Mr Fitzpatrick established the Education Sub-Committee of the Alcohol and Drug Authority and became its Chairman.

The first meeting of the Education Sub-Committee was held in December, 1975; and four subsequent meetings have been held. A number of smaller working groups were established from time to time to research particular aspects of drug education. In addition the Secretary, Mr M Helm, conducted a study tour in August of this year to examine drug education in Eastern Australia. A list of people contacted is to be found in Appendix 1.

0.02 SCHOOLS AND HEALTH

Health education is an essential component of the school's mandate. The "Seven Cardinal Principles of Secondary Education" published in the United States in 1918 are as follows :

> Good health
> Command of fundamental processes
> Worthy home membership
> Vocational efficiency
> Good citizenship
> Worthy use of leisure time
> Ethical character (Ahmann and Glock, 1963, p. 47)

In Western Australia, the most recent comprehensive statement of the aims of education saw them as :

> Intellectual Development
> Integration into Society
> Physical and Mental Health
> Economic Competence
> Emotional and Spiritual Growth (Education Department of Western Australia, 1969, pp. 59 - 61).

Elaborating on the health objective, this report stated :

Education should promote the student's physical and mental health by helping him

(i) to understand and control his body and emotions;

(ii) to follow accepted health and safety practices;

(iii) to cultivate recreational interests and to foster a continuing concern for personal fitness;

(iv) to appreciate and support the services of health and safety authorities; and

(v) to recognize health as a world-wide problem.

It is clear that the health of the student has been a long-standing commitment of the school and that responsibility has been acknowledged by the Education Department of Western Australia.

Two major reports on education had these points to make with respect to the problems associated with drug use :

> We have said nothing so far on the question of health, although it plays a large part in many statements about the purposes of schooling. The maintenance of personal and community health is only to a small extent the direct responsibility of the school, although the school should teach about health, make clear the conditions necessary for personal health, encourage desirable health habits and provide facilities for the development of good physical and mental health. In doing all these it cannot avoid undertaking studies in human biology and in the effective use of human physical capacities. It is reasonable to expect the schools to teach objectively about smoking, alcohol and drugs so far as these affect health and thereby create personal, interpersonal and social problems. It is, however, not reasonable to expect teachers to inculcate particular attitudes to, and values about, such matters when society itself is not prepared to adopt a clearly expressed policy about them, and when within any group of teachers there may be different views on some of the issues of personal freedom and social values associated with such problems.
>
> (Committee of Enquiry into Education in South Australia, 1971, p 36)

> Cultivation of the senses, hygienic and dietary habits, the struggle against depravity and self-destructive tendencies caused by stimulants of all kinds, should from now on be a prominent concern for every educator who takes his responsibilities seriously.
>
> (Faure et. al., 1972, p 156)

Efforts to reduce the problem of drug abuse have taken many forms, including law enforcement, treatment and counselling. According to Cornacchia et. al. (1973, p 131) it has been realized that "such efforts by themselves are not adequate, do not reach people at the most appropriate times, nor are they sufficient in themselves to prevent or reduce the problem". The authors continued that as a consequence society was turning to educational institutions for help, with the emphasis being placed on a preventive approach. They concluded that "the school is expected to act as society's officially designated primary educational agent despite the lack of appropriate guidelines and model programmes".

Although the school may be expected to assist in solving this problem, the following points must be borne in mind :

- There is a tendency for society to believe that a wide range of social problems can be solved by better schools and longer schooling. Pressures for schooling continue to mount but there is scant evidence that the schools can solve society's problems.

- Health education programmes aimed at reducing the incidence of drug abuse must take account of the main influences on young people in developing attitudes and behaviour patterns. These influences include the family, peers, and the mass media as well as the school. Education through any of these sources will not be fully effective if there is little congruence with other sources.

How successful is an alcohol education programme likely to be in a society where alcohol abuse is widespread? Following an evaluation of various methods of drug education, the London-based Institute for the Study of Drug Dependence concluded that no method is likely to have a very decisive anti-drug effect; teaching about drugs is but one influence among many. (Swift et.al., 1974, p 17).

- There could be an adverse reaction from parents if basic literacy and numeracy skills were neglected in favour of less traditional subjects.

- There does not appear to be any single most effective way for the school to achieve the goal of reducing drug abuse. Nor, it seems, has anyone attempted to define the nature of an adequate programme. Consequently schools must experiment with a variety of methods and may then be criticized for ineffective programmes. (Cornacchia et. al., 1973, p 132).

The Sub-Committee, however, does not see drug education as a major new preoccupation, but as part of an overall programme of developing physically and mentally healthy students, a programme which may be seen as part of the existing subject areas of the school, and which depends as much on the way in which education takes place as on the subject matter which is imparted.

0.03 THE EXTENT OF THE DRUG PROBLEM

Appendix 2 contains a number of quotes from surveys of drug taking by students in Australia. It appears from these surveys that abuse of alcohol is the largest drug problem faced by Australian students. However the surveys do not seem to provide a complete coverage of drugs as defined in this Introduction. Substances such as medically-prescribed drugs, vitamin pills and laxatives are drugs according to the Sub-Committee's definition, and decisions about the ingestion of these substances must, like all drug consumption, be guided by an understanding of health.

Interviews throughout Australia reveal that the following types of drug abuse or misuse by students are causing the most concern:

- abuse of alcohol
- use of cigarettes
- misuse of over-the-counter drugs such as minor analgesics
- abuse of illegal drugs, particularly marihuana
- brewing of certain plants
- inhalation of certain common household products
- multiple drug taking in which at least two types of drugs are taken in combination causing a more significant effect that the consumption of either in isolation.

The Sub-Committee wishes to point out strongly that it does not see drug taking by young people in a cataclysmic perspective. In some cases of drug misuse or abuse young people are merely following accepted community patterns of behaviour. In other cases their actions may be seen as a normal response to particular situations or stresses for which no alternative courses of action are perceived. In some cases drug taking by young people is judged by their elders by means of "double standards" - for example, the elder may be a chronic abuser of alcohol, yet may see his drug use in an acceptable light while deploring experimentation of young people with marihuana.

It can thus be summed up that drug abuse problems are widespread in our society, and non-normal types of drug misuse or abuse by young people should be viewed in this perspective. However, the drug problem is a health problem, and to the extent that the school should be concerned with the health of the student, it has a responsibility to be concerned about drug taking. The school has an important potential role to play in the preventive approach in health matters.

0.04 DEFINITIONS

The following definitions underly the statements made in this Report.

DRUG: A substance which when taken into the body modifies mood, behaviour or bodily function. When used illegally the term "drug" is interchanged freely with the term "narcotic".

DRUG USE: Consumption of a drug.

DRUG MISUSE: Periodic or occasional improper or inappropriate use of a drug or drugs.

DRUG ABUSE: The use of drugs, chemicals and other substances to the possible detriment of the individual's health, or his economic or social adjustment; or to the possible detriment of society.

DRUG EDUCATION: This means different things to different people. Some people see drug education as imparting information or moralizing about drugs while others see it as mere development of a person's ability to cope with stress and make decisions for himself. While the term is of necessity used in some of these different ways in this Report, the Sub-Committee sees drug education as an integrated component of education as a whole and of health education in particular. The Sub-Committee believes that drugs should not be emphasised but seen in this integrated perspective.

CHAPTER 1

PRINCIPLES OF HEALTH EDUCATION

The following principles of health education, especially in relation to the use of drugs, have been agreed upon by the Sub-Committee. In drawing up these principles, the Sub-Committee was assisted by consultations with a wide variety of experts in drug education and treatment throughout Australia.

1.01 DRUGS SHOULD BE KEPT IN PERSPECTIVE

In many ways students manifest patterns of drug taking similar to those of the entire community. Thus, the highlighting of fashionably sensitive social issues, like smoking of marihuana, should be avoided. This amplifies a generation gap; whereas attempts should be made to increase communication between the generations. Punishment for drug offences achieves little, and enforced rehabilitation is of no use beyond the period of captivity.

School officials should not over-react or become hysterical if students are found taking drugs. In some cases such students have been expelled. This tends to make martyrs of those expelled and can thus be counter-productive. Such drug taking is often experimentation which is a normal process for young people. It is perhaps wisest to provide adequate information to students likely to be in the experimental stage so that they may experiment reasonably healthily. A common reaction if taking of drugs such as marihuana is discovered at a school is to bring in a guest speaker and a film on drugs which, as will be seen later in this Chapter, may be counter-productive.

1.02 IT IS IMPORTANT TO RECOGNIZE THAT NO EDUCATION PROGRAMME CAN ELIMINATE ALL UNDESIRABLE BEHAVIOUR

The school is not the sole drug reducing agent; it will have little influence if other agencies of socialisation, for example, peers and the mass media, do not complement it. Dealing with a school drug problem involves a global effort, with contributions by educationists, social workers and other professionals; and various government departments.

Parents and the community should be involved in a child's health education as much as the school.

1.03 DRUG EDUCATION SHOULD BE SEEN AS PART OF A TOTAL HEALTH EDUCATION PROGRAMME

There seems to be a tendency on the part of most people to want to fragment the health area into a number of problems. These problems are subject to change according to what are currently sensitive issues. Hence health education is divided into various components: safety, drugs, sex, and so on. This tendency to fragment the health area goes hand in hand with the establishment of committees or agencies dealing with specific areas. At present the Education Department of Western Australia is involved with a drug committee, a venereal disease committee and a sex education committee.

Health education in schools must be much more sophisticated and wider in scope than the simple lessons in hygiene, posture and anatomy which characterised the early texts and procedures. Topics such as these are only a small part of the health education process; and teaching exclusively about them is not satisfactory because it does not take into account the physical, mental and social dimensions of man. Subscription to the tendency to fragmentation in health education results in people being unable to see the common elements in all health problems. These common elements will be recognized by referring to Section 1.05.

1.04 THE OBJECTIVE SHOULD NOT BE PROHIBITION BUT MODERATION AND DISCRIMINATION IN THE USE OF DRUGS, AND TOLERANCE OF THOSE WHO MAY NOT WISH TO DRINK ALCOHOL OR PARTAKE OF OTHER DRUGS

Prohibition is probably only effective for those who would not use drugs in any case. Absolute avoidance is not what is required, but drugs should be used according to the advice of experts, for example, doctors; and according to one's own judgement. The problem is not the existence of drugs, but the use to which they are put.

1.05 THE EMPHASIS OF HEALTH EDUCATION SHOULD BE ON SELF MANAGEMENT, DECISION MAKING AND FREEDOM TO CHOOSE

A recent Education Department publication stated:

> ... we live in a rapidly changing world where it is not possible to provide students with ready made solutions to the problems they will meet. Therefore, there is need to encourage students to think for themselves, to listen to various points of view and to make their decisions, at the same time being aware of the possible consequences of those decisions.
>
> (Education Department of Western Australia, 1972, p 3)

The youth of our society is faced with enormously important decisions of which drinking, driving, drugs and sex are only few examples. Individuals of the future may be faced with difficult decisions resulting from, for example, genetic counselling, euthanasia, and sterilisation. Thus in order to equip future citizens to cope more effectively with the many dilemmas which may confront them the school must concentrate its efforts towards developing the decision making process. The developing child needs progressive opportunities for attaining the power, the security and the self esteem to make his own decisions. Young people should be given sufficient facts to know the consequences of their decisions, and to make their own informed decisions. A balance is needed between giving the facts and developing decision making processes. Self control is essential; and self control is related to self esteem.

It is undesirable to force young people to adopt or not to adopt particular types of behaviour. If parents, teachers and society make all the decisions throughout children's lives then adolescents cannot be expected to make rational, responsible decisions about, say, drugs or pre-marital intercourse when suddenly confronted with a situation which calls for a decision. Decision making is a skill which must be learned and practised. The principles of transfer of learning apply. Making decisions about one aspect of health develops skills which may be applied across the health spectrum.

Hopefully the outcome of such a programme in terms of drug taking would be people distinguishing for themselves what drugs mean to them, and being cynical of the support given by drugs. The objective is not to reduce drug use, but to reduce drug abuse. The role of education is not to prevent drug use but to encourage people to make their own informed decisions. It is possible to have drug education without talking about drugs at all. Good education is good drug education because, inter alia, it develops individuals' capacities for decision making.

1.06 THE CLASSROOM TEACHER SHOULD BE THE PRIMARY HEALTH EDUCATOR IN THE SCHOOL

Teachers have the advantage of knowing their pupils and the educational process. There is not a sufficient number of outside health educators to conduct a suitable long term programme. Speakers from outside the school

should be used with discretion. Smart and Fejer (1974, p53) have suggested that students tend to trust experts in the field of drug use for their information more than teachers. However the authors continued that the experts were often forced to address large heterogeneous audiences where smaller groups with greater personal communication would be more suitable. In addition to the points made by Smart and Fejer, outside experts constitute a scarce resource. The only large scale potential source of health educators lies in the ranks of classroom teachers. They are able to develop a continuous programme of health education oriented towards decision making on the part of the individual student. Outside speakers when used should be part of an integrated programme of health education at the school. The role of the teacher as being responsible for the education and pastoral care of students should not be abrogated in favour of occasional speakers.

Ex addicts should not be used to address students on drugs. The incorrect non verbal message given by ex addicts is that cure from, say, heroin addiction is not difficult. In addition, ex addicts are often charismatic types and children may see a connection between an ex addict's charisma and his prior use of drugs.

Non school agencies involved with health education should concentrate on education of teachers, and should act as resource bodies for others in the community rather than conducting programmes themselves. They may also help community groups to develop their own health education programmes.

1.07 INFORMATION ALONE IS OF LITTLE USE IN CHANGING ATTITUDES OR BEHAVIOUR

Drug education is not merely education about drugs. Drug problems are "people" problems, so the pharmacological or anatomical aspects should not be overstressed. Most programmes have an information component. This is necessary because if it is lacking, children may become disenchanted over not obtaining the answers they want; and may suspect the educator's competence. Information giving is possibly dangerous unless part of a debate or an on-going process. Excessive detail may not only arouse interest and encourage experimentation, but provide information on "how to do it".

Information should not be blown out of proportion. It should be factual, scrupulously honest, and present the pros and cons of drug taking. It should relate to the attitudinal area, for example, related to motivations for taking various kinds of substances. Studies have shown that drug users are as informed about drugs as most students, but this knowledge has not deterred them from drug use (Egger et. al., 1976, p 9; Smart and Fejer, 1974 p37).

1.08 THE USE OF FEAR IS NOT A SOUND BASIS FOR HEALTH EDUCATION

There are conflicting views on the use of fear in anti-drug programmes. On the one side it has been argued that fear is a part of life and so may play a part in such programmes; and that fear may be a strong factor in motivation. However, it appears that adherents to this viewpoint who have been professionally involved in such programmes would be reluctant to rely upon fear alone. They often feel that whilst people should not be shielded from fear, the fear aspect should not be emphasized; however it may carry people over the first few days of an intensive anti-smoking programme, for example. Groups which have admitted using the fear approach have said that they used this method in the early 1960's; but so did a large number of well meaning organizations which were not aware of the adverse effects which chould result.

On the other hand the predominant opinion of professionals working in the area of drug education and treatment is that fear tactics are at best of no value and at worst counter-productive. It has been said, for instance, that fear tactics are emotional, often giving false information and hence discrediting the programme and causing mirth to students; that films about the seamy aspects of drug taking give some people a feeling of mystique about drugs; and that some are attracted by the promise of danger. Stressing the dangers of drugs may result in a "wet paint" effect (children wanting to touch after they have been told not to). It may whet the appetite and encourage experimentation.

It has been suggested that the people liable to be frightened by fear campaigns probably would not use drugs of the nature described anyway; and that there is no evidence that knowing the problems associated with drugs will deter drug taking.

Smart and Fejer (1974, pp14, 32, 38) have pointed out that research on the use of fear in drug education contained many conflicting results, even when applied to drug users; fear appeals or scare tactics had fallen into unjustified disfavour but few studies had attempted systematically to assess their effects on drug use, behaviour and attitudes.

The Sub-Committee feels that education materials based on fear alone should not be used because they often involve explicit details which may encourage experimentation with drugs. Fear appeals do not appear to have been successful in overcoming problems such as the road toll and unwanted pregnancies. Education programmes should be directed towards long term solutions rather than any possible short term effects of fear campaigns.

1.09 SCHOOLS DO BEST IN PROMOTING A POSITIVE APPROACH RATHER THAN TRYING TO INCULCATE NEGATIVE ATTITUDES

Teachers should not concentrate on telling students what not to do. This involves the "wet paint" syndrome - if children are told not to touch this is exactly what many will want to do. A teacher may promote his own view on occasions but with older students he should make it clear that it evolves from his own standards.

Students should be advised of alternative activities available to them, for example, recreational activities and participation in social change. A recent report on adolescents and alcohol in New South Wales stated :

> As well as dealing in cognitive and affective domains, it seems necessary that planners try to ensure that physical resources are available to provide alternative sources of social and leisure satisfaction for young people and try to create awareness of those resources and readiness to use them. It appears from the survey that some of the constant excessive use of alcohol arises from either the failure of young people to perceive that there are other uses for leisure time, or from the failure of society to provide adequate and acceptable facilities for such activities (Egger et. al. 1976,p 10).

Moralizing to students about correct behaviour is of limited value. Westerhoff (1973, pp 225 - 226) has pointed to the futility of this and similar approaches :

> It is only natural that we try to communicate our own values to children and youth. We talk about setting an example or pointing toward good examples. We try to persuade or convince a child, through dramatic or emotional pleas, that this or that set of values is the one for him to follow. We set rules and regulations, we reward or punish to mould his behaviour in certain "right" directions. We present certain values as having a religious base and use the authority of religion as a persuader. We appeal to conscience, that still voice that we assume is in the heart of everyone. With deep concern, we moralize and lecture about charity, courtesy, honour, perseverance, and other values we think important.
>
> But deep within us, we know the futility of all such approaches. Just as you cannot give a child a faith, you cannot give him values. They cannot be injected like a vaccine. A child is a person; we dare not rob him of his freedom. You can influence, offer guidance, and confront him with decisions, but little more. Still, you can enable a person to clarify his own values and thereby evolve a permanent set for his life.

Students should be encouraged to develop the ability to cope with stress as it arises. An atmosphere of humaneness at the school is important because of its role in reducing school maladjustments and consequent stress.

1.10 A DISCUSSION - ORIENTED APPROACH TO HEALTH EDUCATION IS REQUIRED

The ideal channel is face-to-face contact, with small group discussions and the teacher attempting to answer questions. This seems to have more influence than audio-visual materials (Smart and Fejer, 1974 p. 20). Previous sections have pointed to the undesirability of the "shotgun" approach, which means rounding the students into a large assembly and trying to scare them often with the aid of speakers who were ex addicts.

It is desirable that the teacher be a resource person for a peer group education process. The peer group is needed to facilitate changes in people because it is one of the most likely influences on attitudes to drugs and alcohol.

1.11 HEALTH EDUCATION IS A LONG TERM PROCESS

The results of any school programmes may not be seen for at least a generation. Health education should span a number of years. Programmes should be continuous and not sporadic. Expectations of effective outcomes of health education should be based on long rather than short courses.

1.12 COUNSELLING IS COMPLEMENTARY TO EDUCATION

There should be early crisis intervention with students likely to be "at risk" in terms of involvement with drugs. The development of some elementary counselling skills by teachers would be advantageous. Punishment is of little value. It is preferable to provide counselling to develop self-confidence and responsible autonomy.

RECOMMENDATION 1

School education programmes relating to the use of drugs should be conducted in accordance with the principles espoused in this Chapter.

2.01 TEACHING ABOUT DRUGS

There are two major, but not mutually exclusive, views about how drug education may fit into the school curriculum.

The first is that drug education should be part of special courses designed to promote healthy development, physically, mentally or emotionally. The obvious example of such a course is health education, which is generally not given high priority by Australian schools. Health educators have stressed that drug education should not be a single pre-occupation but should be seen as part of an overall programme of health education, of which many principles and concepts apply to drugs and to a host of variables which may affect the performance of the body and the personality.

Health education could be seen in this way as incorporating subjects such as nutrition, safety, dental health, social health, family health, and consumer education. Health educators seem on balance keen to see drug education integrated into school subject areas other than health education. In addition to health education there are programmes such as Personal Development in New South Wales and Workshops in Human Relationships in Western Australia which occupy a small number of periods in the school week. The Sub-Committee has discussed the Workshops programme and its conclusions were that it had not been well implemented and had fallen into disrepute. There had been too much emphasis on content, rather than on the spirit of the programme. The stimulatory material and strategies supplied with the course, while varied in terms of ideas, were inadequate in that they were limited to the written word. Students soon became bored with receiving the same type of material each week and performing the same types of activities based on that material, and teachers were not encouraged to vary their classroom approaches. It was difficult to develop the right atmosphere for discussion in a stated period each week. There had also been timetabling problems. The success of the Human Relationships programme depended on the availability of an enthusiastic resource person and administrator. Teachers had not been adequately prepared to embark on this programme. It often resulted in teachers moralizing to students. There was usually one period per week in health education and one in Human Relationships. But Human Relationships paralleled health education, and health education books were superseded by those of Human Relationships. The Human Relationships classes were used to top up teachers' timetables. This often resulted in teachers taking Human Relationships with a class they saw only once each week. The Sub-Committee believes that experiences with this programme indicate the importance of teacher education for the success of similar programmes in the future.

It has been said of the Personal Development programme that few teachers are able to teach it, and the schools in disadvantaged areas which need it most get the least prepared teachers. One of the overall criticisms of such special programmes is that because they are given outside the normal curriculum, they lose parity of esteem with the normal curriculum in the eyes of the students, and hence their effectiveness is diminished.

The other view is that the best avenue of drug education is probably through the normal curriculum. It is much easier at the primary level to integrate health education into traditional courses, but it is possible at the secondary level to integrate drug education into subjects such as the physical, chemical, biological, social and domestic sciences, mathematics and English.

The Department of Education and Science of the United Kingdom (p 16) stated that drugs should be considered as part of an overall programme of health education and not as a series of prohibitions: this should be part of a positive policy of introducing intelligent and informed approaches to health problems.

The Sub-Committee supports the development in the first place of a strong health education programme of which information about alcohol and drugs is a part; plus a flow over of drug-related education into other subjects of the curriculum as the opportunity arises. Stronger administrative support should be given to health education, and such support could be shown by

giving a specific responsibility of promoting it to a senior Education Department officer, by establishing a strong and effective health education advisory committee, and by developing suitable curricular and audio-visual materials. Promotional avenues for teachers well qualified in health education would be another means of promoting it.

2.02 THE NATURE AND TIMING OF DRUG EDUCATION PROGRAMMES

Answers to questions about the age at which drug education should be given and how much information about drugs should be provided to students are not unanimous.

On the one hand it has been argued that information given at too early an age could advise innocent children specifically about how to take certain drugs, and also encourage experimentation. On the other hand it has been argued that children learn about drugs from the cradle onwards, that they will continue to find out about drugs from parents, their peers, the media and other sources, and to ignore the question of drugs is to adopt a "head in the sand" attitude whilst children are affected by drug problems all around them. In addition, providing objective facts might help to counter the sensationalist approach of the mass media.

The solution to this dilemma appears to rest on the classroom teacher. The teacher is in the best position to know the types of drugs, if any, with which the children in his class are involved, and to provide the necessary information for his pupils to assess the consequences of their actions. Involvement by children with different types of drugs will vary according to age, ethnic background, socio-economic status, sex and other variables. By various pedagogical approaches such as discussion sessions with an emphasis on decision making, teachers can concentrate on the particular aspects of drugs troubling the particular students they are teaching. If students were told about unknown drugs they would become curious but if a topic relating to a particular drug were introduced by a student, the teacher could allude to it in a non-emotional manner. The Technical Information Bulletins from the National Drug Information Service should be sent to counsellors and people responsible for drug education programmes, but not directly to children. Teachers should be provided with the resources to assist children to find the answers to questions about drugs.

The Sub-Committee believes it to be desirable that drug education commence at the early primary school level as part of an integrated programme of health education. It has been suggested that maximum susceptibility to drug education occurs at the age of 8 or 9 years in North America, after which susceptibility falls until adolescence when it tends to stabilise (Smart and Fejer, 1974, p. 17).

Emphasis in the early primary years should be on alcohol and over-the-counter drugs. With younger children, minor analgesics constitute a major problem, although some students are addicted to alcohol and cigarettes by about age eleven or twelve. Emphasis at the primary level should be on cognitive rather than affective learning outcomes.

In terms of content, it has been suggested that in the primary grades the major emphasis should be on the physiological and pharmacological aspects while at the high school level the focus should be on the psychological, sociological and spiritual aspects with limited concern for the physiological (Cornacchia et. al., 1973, pp 153, 157). The Sub-Committee believes that health education programmes in general should aim at developing an understanding of health problems, and should stress the alternative courses of action open to individuals.

The methodology and content of health education courses in schools should be a subject of continuing analysis and evaluation. The Sub-Committee is aware of two methods which deserve further consideration. These are transactional analysis and values clarification. However, these are just two of a number of approaches which may be used. Over-reliance on any one method would appear to be undesirable.

2.03 HEALTH EDUCATION IN THE EDUCATION DEPARTMENT OF WESTERN AUSTRALIA

A health education unit was first established in the Education Department in the early 1960's. The present staffing of this unit is four persons. When the unit was first established, one part-time officer was occupied in this work although considerable help was received from the Health Education Council.

Both primary and secondary syllabus committees were established and produced syllabuses accompanied by textbooks. A widely representative committee including representatives of the Education Department, the Teachers' Union, the Council of State School Organisations, the Health Education Council and the Marriage Guidance Council was established to draft a sex education policy. Following this a primary Growth and Development committee was formed and produced a programme which has been in use in trial schools for a number of years. All of these committees are responsible to the Director-General of Education. In 1973 a working party was established. This was convened by the Commissioner of Public Health and included representatives of his Department, Mental Health Services, teachers' colleges, the Health Education Council and the Education Department. This working party laid out broad guidelines, and established other working parties which have continued to meet.

The Education Department gives each school a large degree of responsibility for its own curriculum. However, no school is autonomous since there are both implicit and explicit guidelines laid down by the Department, while the expectations of parents also constitute a restraint.

The Department's health education syllabuses for Years One to Ten and the combined Health Education/Human Relationships syllabus for Year Ten are included in the list of references. It is not possible to quantify the degree of compliance with either the primary or secondary syllabuses. It is believed that the primary syllabus is used quite extensively and is closely complied with; however, a number of secondary schools no longer teach a separate subject entitled health education but integrate this work with other subjects.

The Growth and Development syllabus which has been used in a limited number of primary schools up to this time is to be made available to schools wishing to use it in 1977. The Department's view has been that drug education as such should not be taught in schools but that drugs and alcohol should be seen as a response to societal problems. Its programmes have been based on this fundamental assumption.

The Education Department's Primary School Health Syllabus makes no specific mention of alcohol and drugs, although some of the topics are sufficiently broad to enable discussion of such matters. At the secondary level isolated topics in the Human Relationships course for Years Eight, Nine and Ten refer to alcohol and drugs, and also a small number of specific booklets produced by various authorities are available for distribution to students. However, the quality or even existence of discussion or booklets on alcohol and drugs may vary markedly from one school to another.

Schools receive substantial funds to purchase teaching aids. There is no requirement for them to purchase such aids for the teaching of alcohol, drug or sex education. There are no explicit guidelines. However the Library Services Branch which catalogues material draws possibly objectionable material to the attention of school principals for their decision. The Teaching Aids Advisory Service was recently established as part of the Education Department's Curriculum Branch. The Service is responsible for evaluating audio-visual education materials which come to its attention, and its advice is available to both government and non-government schools. It is currently establishing a committee to evaluate drug education materials.

TAPES:

Community Development Centre, Mental Health Services

The Sub-Committee concluded that:

1. No one seems quite certain as to how alcohol and drug education in schools should be conducted. One thing is certain however: principals and teachers need positive direction from this Sub-Committee to help them plan their programmes.

2. There is a significant shortage of carefully prepared, satisfactory material in the field of alcohol and drug education available to teachers. Different teachers discussing drugs did not co-ordinate, and in fact often contradicted one another. The library resources person could do more than anyone else and could make or break attempts at drug education. New material should be provided for different grades so that pupils did not use the same material each year.

WRITTEN MATERIALS:

Year 8 - Where There's Smoke
Year 9 - Alcohol and You
Year 10 - Consequences No 14 (Education Department of Western Australia)

FILMS:

Nil

It is impossible to generalize about the extent to which secondary schools are involved in alcohol and drug programmes as no statistical information is available at this stage.

Two high schools were known by the Sub-Committee to be involved in such programmes however; and a brief survey indicated that their materials were obtained from the following sources:

WRITTEN:

Department of Health (Commonwealth)
Department of Public Health, New South Wales
Education Department of Western Australia
Health Education Council of Western Australia
Seventh Day Adventists
Social Security Department
United Nations

FILMS:

State Film Centre. Films include:

Alcohol and the Human Body
Alcohol - A New Focus
Alcohol - How Much is Too Much?
Drugs - Use or Abuse
Focus on L S D
Mr Fixit - My Dad
Smoking - A New Focus
The People Next Door
The Secret Love of Sandra Blain
Tobacco and the Human Body
What About Drinking?
Where Are We Heading?
[illegible]e There's Smoke

Schools may at their initiative invite outside speakers to talk to students on a large number of matters. The Department makes no requirement that schools should consult with the central administration upon this matter. It is known that the Health Education Council, the Planned Parenthood Federation and a number of other community bodies are actively engaged in school programmes.

2.04 TEACHING AIDS CURRENTLY AVAILABLE

The Sub-Committee conducted an analysis of teaching aids pertaining to alcohol and drugs which were currently available in Education Department schools. Its findings follow.

A perusal of the material available shows that at this stage no serious attempt has been made by the Department to produce relevant and up-to-date booklets, pamphlets or films.

Items which are available to teachers and students concerning drugs and alcohol are as follows:

3. Only one or two items of value are produced by the Education Department.

4. The Health Education Council is a valuable source for materials.

5. There seems little point in involving the Curriculum Branch in developing curriculum materials out of the context of a total offering of health education materials.

6. As an interim measure the Department could set up a clearing house for all related programmes and materials and make principals fully aware that such a resource centre were available. (This conclusion was arrived at prior to the Sub-Committee being informed of the impending involvement of the Teaching Aids Advisory Service in evaluating drug education materials; but it is desirable that this need be stated clearly in this Report).

7. Publishing companies represent a confusing and sometimes dangerous source of supply. Direction and guidance to principals and teachers is certainly needed with regard to commercial sales and packaging of materials. In all sincerity, a principal could buy costly materials which are not only useless but possibly dangerous.

RECOMMENDATION 2

That a strong health education programme with emphasis on the early primary level be mounted within the Education Department of Western Australia, supported by an administrative structure which is able to provide effective backing to such a programme.

2.05 HEALTH EDUCATION IN NON-GOVERNMENT SCHOOLS

Because of the autonomy of non-government schools it is difficult to quantify their degree of involvement in health education. It appears, however, that like government schools, non-government schools give relatively low priority to health education, and the degree of involvement of individual schools to a large extent reflects the availability of local personnel. The provision of drug education at non-government schools is even more remote. In those cases where it does occur there is often an awareness of the counter-productive effects of particular approaches, and attempts are made to avoid dysfunctional outcomes.

2.06 NON-SCHOOL AGENCIES INVOLVED IN DRUG EDUCATION

The following agencies have come to the attention of the Sub-Committee:

1. The Health Education Council Of Western Australia

The Council is funded jointly by the State and Federal Governments and has statutory responsibility for health education in general. Appendix 3 is a statement produced by the Council illustrating its philosophy and methods of operation.

The Sub-Committee believes that the Health Education Council is one of the most valuable support agencies for school health education programmes, both in terms of provision of resources and personnel; and the experience of the Council should be utilized in developing school programmes. Rather than conducting school health education programmes itself, the Council is probably best suited for developing resource material, mounting community programmes and assisting with pre- and in-service education of teachers. The Education Department could also maintain a close relationship with the Council through bodies such as the Department's Teaching Aids Advisory Service which is concerned with the evaluation of audio-visual education materials.

2. Seventh Day Adventist Church

Drug education programmes emphasise nicotine and alcohol although the illicit drugs are also dealt with. The Church tries to point to the positive aspects of living and the need to turn to natural dependencies to solve problems. It is aware of the inducement to experiment caused by explicit material; however on special occasions explicit material may be presented. The anti-smoking programmes point out the physical effects of smoking. Requests for Church personnel to provide drug education in schools are ususally made in connection with anti-smoking programmes. They usually take the form of a lecture; and are not more frequent than once per year at individual schools.

3. Community Development Centre, Mental Health Services (Government of Western Australia)

The Centre which seeks to promote mental health in the community provides community education programmes to a wide range of community groups including some high schools. A large part of the programmes comprise workshops in human relationships. No programmes are concerned specifically with drugs.

4. Child Health Section, Department of Public Health (Government of Western Australia)

Over thirty nurses are currently attached to the staff of government schools. They participate in health education programmes, including the provision of information to students on problems of drug and alcohol ingestion, if such assistance is requested by the school principal. Doctors and nurses of the Section are frequently asked by schools to assist with health education programmes and also address school staff. Involvement in the student education programmes takes the form of small discussion groups and it is considered desirable not to focus attention on addictive drugs.

5. Community Health Section, Department of Public Health (Government of Western Australia)

This Section is directed to all members of the community, its prime function being to combat and prevent illness through the medium of health education. It is mostly involved with Aboriginal parents in remote areas of the State. Its work in schools is in association with the school nurse.

6. Christian Welfare Centre of the Churches of Christ

A representative of the Centre attends high schools to address students on the question of drugs.

7. Other Organizations

Intermittent involvement in drug education is undertaken by groups such as religious sects and community service organizations. Members of the medical or associated professions may give occasional addresses. Occasional seminars occur at post secondary educational institutions.

The Sub-Committee believes that the use by schools of the services provided by these agencies should be in accordance with the principles espoused in Chapter 1 of this Report.

2.07 EVALUATING DRUG EDUCATION PROGRAMMES

Because of the wide range of variables influencing attitudes and behaviour in relation to drugs it is difficult to evaluate drug education programmes. Other difficulties militating against evaluation are difficulties in defining terms such as "abuse" and "cure". Smart and Fejer (1974) have suggested that the major problem in evaluation is in determining what constitutes a favourable outcome, and the methods of assessing the outcome. In relation to the latter problem, a question which arises is whether a measure of attitude change can be taken as an indication of potential drug use. Another problem is the question of how long-term will be the effectiveness of a drug education programme. For instance, an evaluation conducted immediately after the conclusion of a drug education programme will be of a situation which may or may not remain after the passage of time. Another problem is the difficulty of establishing control and treatment groups for the purpose of experimenting with particular programmes. The authors stated that in comparison with the vast number of drug education programmes which have been implemented, the number which has undergone even a rudimentary evaluation is very small - not more than a few dozen. The number of programmes having any sort of published evaluation exhibiting basic features of careful experimentation is probably fewer than a dozen; those showing a comparison against a non-treatment control group being no more than eight. Even fewer than eight have studied the effects of drug education programmes on drug use. The same authors said that because of the influence of so many variables one cannot even guess at the relative effectiveness of different types of programmes. They felt that there is a great need to evaluate, for instance, teacher education programmes in a more scientific and systematic fashion than has occurred so far. To them:

> Drug education as currently practised has been called a hoax, a fraud, and an educational abortion. At present, even its most ardent supporters would have to admit that drug education has had few striking successes: and a handful of replicated programmes have shown validated effects upon actual or reported drug use. However, fad, fashion and good taste still largely dictate the choice of any drug education programme. The apocalyptic horsemen of drug education are over-use and lack of evaluation in exact criteria and effectiveness; together, they threaten its death. (Smart & Fejer, 1974, p vii)

In one published evaluation, the London-based Institute for the Study of Drug Dependence (Swift et. al., 1974) examined a number of methods of drug education, bu none stood out markedly as a desirable method to be implemented on a widespread basis. The report concluded that the findings reassure teachers that if mistakes are being made in drug education, their consequences are unlikely to be grave: it stated that teaching about drugs is one influence among many.

Evaluation of drug education programmes in Australia has been infrequent. A report produced by the Queensland Education Department has evaluated that State's programme but it is not yet available.

Smart and Fejer (1974, pp 8[illegible] - 87) have suggested a few general principles of evaluation of drug education programmes. These are:

1. All evaluations should measure the pre-programme and post-programme situations, and a follow-up measurement should be taken after a period of time.

2. Evaluation instruments should be reliable and valid.

3. Emphasis should be on changes in drug attitudes and drug use rather than merely a change in knowledge.

4. Effects need to be judged over a long period of time.

The Sub-Committee recognises the difficulty of evaluating programmes of drug education, particularly if they are conducted within an integrated programme of health education. Officers involved in health education curriculum development should develop built-in evaluation procedures for any curriculum material which is produced.

2.08 THE HIDDEN CURRICULUM

The structure and functioning of the school is at least as important in the education of children as the curriculum itself. As Silberman (1972, p. 6) suggested:

> What educators must realize, moreover is that how they teach and how they act may be more important than what they teach. The way we do things, that is to say, shapes values more directly and more effectively than the way we talk about them. Certainly administrative procedures like automatic promotion, homogeneous grouping, racial segregation, or selective admission to higher education affect "citizenship education" more profoundly than does the social studies curriculum. And children are taught a host of lessons about values, ethics, morality, character, and conduct every day of the week, less by the content of the curriculum than by the way schools are organized, the way teachers and parents behave, the way they talk to children and to each other, the kinds of behaviour they approve or reward and the kinds they disapprove or punish. These lessons are far more powerful than the verbalizations that accompany them and that they frequently controvert.

To give some examples of the effects of the hidden curriculum, it may be that the factors working towards conformity in the school are working in opposition to the need for alcohol drinkers to be tolerant of those who do not wish to drink alcohol. In addition, teachers are often used as models by young children, and the sight of teachers smoking, for instance, might undo the value of the health education they had given to students.

The proposed memorandum to school principals (Appendix 4) prepared by the Sub-Committee discusses the question of teachers smoking at school.

2.09 SCHOOL COUNSELLING SERVICES

A number of professionals in the drug education and treatment field in Australia have referred to the lack of sufficient counselling personnel available for students who may be having problems with drugs. It has been suggested that there is an urgent need for more counselling services for students to help them to cope with stress. According to this view authorities do not have the luxury of educating now to prevent drug taking in the future - there are drug problems in the schools now. What is said to be required is an increase in counselling services in schools to assist children with emotional problems. Children should have as many such services

available to them as adults. Teachers are currently not equipped for the task of counselling. It may not be necessary to provide social workers for every school, but selected teachers with a flair for counselling could be trained for this work. According to this view a broad educational approach to drugs runs the risk of encouraging experimentation; hence higher priority should be given to the provision of counsellors.

The Sub-Committee does not entirely agree with this point of view. While adequate provision of counsellors should be made for students, it attaches priority to the role of education as part of a long-term preventive approach to health. It agrees that the teacher can play a significant counselling function. This is pointed out in a recent Education Department report on the role of the guidance officer which suggested:

> Following closely upon the above is the need to clarify the misconception that guidance is the province of specialists. While we look to the guidance officer for the professional leadership necessary in an effective guidance programme, this does not and should not relieve other school staff of the responsibility for dealing with students' behaviour and development. Whether teachers and administrators, talk, counsel, hold private conferences, workshops in human relationships, small group tutorials, etc., they do have interaction with individual students. These contacts must be as useful as possible.
>
> There are a number of reasons why the classroom teacher must be considered an important guidance worker in the school. First of all, we know that learning is most effective when material to be learned is directly related to the immediate personal goals of the learner. Teachers who are concerned with the individual aspirations and problems of their students will thereby set up the most effective learning situations. In short, the guidance approach to pupils makes teaching more effective. Secondly, teachers who interact, listen and relate to their students are more sensitive to what is and what is not transpiring in the classroom. They are able to make a more effective contribution to programme planning and curriculum revision. Teachers have certain advantages over specialists in serving as guidance workers. The classroom is a life space which encourages more natural counselling than a treatment clinic or strange office out in the community. A teacher can observe students more frequently than specialists and in more varied situations and circumstances ...
>
> The skills necessary for the successful performance of these functions should have been obtained as part of the teacher's pre-service education. However an in-service training programme can provide the <u>additional skills</u> needed by those teachers who are given <u>special responsibilities</u> in the guidance programme. (Education Department of Western Australia, 1976, pp 10-11)

Section 3.01 of this Report gives further consideration to the need for pre- and in-service education of teachers.

Available services for counselling of young drug abusers include:

1. <u>Drug Unit, Department for Community Welfare</u>

   This is seen as a consultative and resource unit for the use of Community Welfare workers. The Unit is in its fourth year of operation and is staffed by one social worker.

2. Western Australian Alcohol and Drug Authority

The Authority, established in 1974, counsels adolescent clients and their parents. The Authority has four centres offering treatment, out-patient counselling, work rehabilitation, and retraining in socialisation skills. Staff include social workers, welfare officers and doctors.

3. Guidance Branch, Education Department of Western Australia

No officers of the Branch are allocated specifically to the area of drugs. Officers of the Branch would prefer to employ a preventative role rather than acting as crisis intervention agents, and to treat cases as part of a total adjustment process.

4. Christian Welfare Centre of the Churches of Christ

The Centre employs two social workers and supportive welfare staff. Drug problems are not the major concern of the Centre. In addition to counselling, the Centre offers support and work therapy.

5. Child Health Section, Department of Public Health

The School Health Section provides a health screening and counselling service to children attending pre-schools and schools, both government and non-government. About thirty nurses are at present attached to schools. Very few students have been presented to them for advice and counselling on drug problems specifically, but in the few cases when drug ingestion has been a problem referral has been made for advice to the Alcohol and Drug Authority.

6. Counselling Service, Technical Education Division, Education Department of Western Australia

The Service comprises 27 counsellors and one social worker. It prefers to emphasise personal adjustment rather than law enforcement. Although aware of some drug taking by students in the Division, staff had not encountered it much in their work. Staff were not well equipped to cope with the issue, and referred cases to the Alcohol and Drug Authority.

7. Student Health Service, The University of Western Australia

The Service has not seen a large number of students with drug problems.

8. General practitioners

While The Royal Australian College of General Practitioners has not formulated a specific policy for handling drug and alcohol abuse it seemed that the Alcohol and Drug Authority and Alcoholics Anonymous were the most frequent destinations of referral. General practitioners were sensitive of the need to warn patients of the effects of prescribed drugs. The College of General Practitioners maintains audio-visual education material about alcohol and drug problems and runs pre- and in-service educational activities for general practitioners.

9. Community Health Section, Department of Public Health

Community Health sisters deal with cases of drug abuse, alcohol being the most common basis of abuse contributing to family and social difficulties which come to the attention of sisters. In cases of drug problems, Community Health works in close co-operation with other organisations.

10. School social workers, Education Department of Western Australia

One social worker had been approached for information. She had

reported that her professional contact with drug involvement among school children had been minimal; but where cases occurred she would recommend referral to the Alcohol and Drug Authority.

11. Student counselling services, The University of Western Australia and the Western Australian Institute of Technology

Representatives of these agencies advised that cases of drug involvement were more likely to come to the attention of student health services.

12. Health Education Council of Western Australia

The Council answered enquiries about drugs and is also an agency of referral.

13. Other church agencies

None of the church agencies contacted offered services specifically directed to drug problems other than in a general context of social adjustment. Most would refer problems to the Alcohol and Drug Authority.

14. Alcoholics Anonymous

This was one of the most frequent destinations of referral by general practitioners.

Concerning the provision of counselling services, the Sub-Committee concluded :

1. Most agencies respond to indications of drug and alcohol abuse within the total contexts of health and personal adjustment. It is necessary to see such problems in these contexts rather than as a law enforcement issue.

2. There is an awareness of the need for counsellors to have available more resource information and policy guidelines on the handling of cases brought to notice.

3. Students may see schools as identifying with law enforcement agencies and there appears to be a need for definition of the legal obligations of school principals and teachers and the strategies to be adopted in cases of drug taking at schools. Clarity is needed regarding the commitments and obligations of school staff to employing authorities, students, parents, and law enforcement agencies.

4. In the school environment the need for counsellors to observe confidentiality was of paramount importance. This raises the question as to whether in some cases teachers, principals, parents or law enforcement agencies should be informed of cases of drug abuse. A code of ethics for guidance officers and teachers should perhaps be drawn up for approval by the Education Department and non-government schools.

5. Uninsightful handling of drug incidents at schools by the mass media appears to have significant dysfunctional effects between students and members of the school staff.

6. Fear of being reported to the police may well be hampering access to available counselling services.

7. A number of young people do not see drug taking as a problem and hence do not seek counselling.

8. There was a need for co-ordination of available services and information on services which were available.

This Chapter has shown that there appear to be a number of unresolved questions in the minds of school personnel about such matters as appropriate methods of education about drugs, and types of action which should be taken in cases of drug taking. The Sub-Committee has prepared a proposed memorandum to principals of government and non-government schools giving advice on a number of these matters.

RECOMMENDATION 3

That the Education Department of Western Australia, the Catholic Education Commission and other non-government schools give consideration to endorsing and circulating the proposed memorandum to school principals which is contained in Appendix 4.

CHAPTER 3

ADDITIONAL MATTERS

3.01 TEACHER EDUCATION

Not only are there adverse effects of inappropriate use of speakers on health from outside the school, but also human resources would probably never be sufficient to conduct an effective programme of drug education from outside. A large number of non-school organizations throughout Australia is involved in drug education programmes in schools, but many of these would prefer that task to be performed within the school, and wish to concentrate more on teacher education in order to work towards this objective.

Teacher training is an essential part of a system of health education. There is no point in preparing audio-visual materials if teachers are not equipped to use them properly. Teachers should also be trained to develop their own curricula. Yet pre-service teacher training in health education is minimal throughout Australia.

The Sub-Committee investigated the pre-service preparation of teachers in health education in this State. Its findings are as follows:

1. Table 1 shows the time allocation given to health education core and elective programmes in the five teachers' colleges in the State. An attempt has been made to quantify the exact number of hours in those courses which relate to drug education, but only a blurred picture is possible.

2. It would appear that the offerings in health education in all colleges are very restricted (15-30 hours core programmes) and that the range of elective offerings in the area is enormous (0-240 hours).

3. Only Claremont Teachers' College offers a full major in health education but Churchlands proposes to offer a concentration of health electives in its inter-disciplinary major component of the Bachelor of Education degree course commencing in 1977.

4. In all colleges there is a strong opinion constantly expressed that any single component such as drug education should not be highlighted nor abstracted from the health education programmes. The following reasons for this were cited:

   (a) Already covered in secondary schools to the point of over-emphasis.

   (b) Drug education is part of health education and should be seen as such. Current research shows that developing a "mystique" in drug education and the use of fear-arousing methods are both counter-productive.

   (c) Lack of college staff expertise in drug education or health education.

   (d) Little or no pressure has been applied to college administrators to recognise drug education as a significant health issue.

5. Staff from most colleges expressed the view that pre-service core (compulsory) courses in health education should be restricted to "survival kit" proportions, that is concepts of health education and an introduction to methods and media. In those colleges where conversion course and mature age students were enrolled the staff felt that more effective teaching was possible. For this reason it was suggested that health (and drug) education emphasis should be focussed on in-service rather than pre-service training.

TABLE 1 - HEALTH EDUCATION PROGRAMMES WITHIN THE DIPLOMA OF TEACHING AT WESTERN AUSTRALIAN TEACHERS' COLLEGES

CORE		CHURCHLANDS	CLAREMONT	GRAYLANDS	MT. LAWLEY	SECONDARY
Do you run a core health education programme in the Dip.Teaching course?		Yes	Yes	Yes	Yes	Yes
Duration of the programme		30 hrs.	30 hrs.	30 hrs.	15 hrs.	26 hrs.
Percentage component devoted to	First aid	0%	20%	30%	0%	60%
	Human sexuality and sex education	15%	50%	20%		) Topic
	Drug use and abuse	15%		20%		) areas
	Personal health decisions	55%				)40% selected
	Social issues	15%		10%		) by
	Methods and media in health education		30%	20%	100%	) students
ELECTIVES						
Do you run health education electives?		Yes	Yes	No	Yes	Yes
Can a student complete sufficient hours to MAJOR in health education?		No	Yes	No	No : But students majoring in PE may take 45 hrs. Health	No : But students majoring in PE must take 4 x 26 hrs. Health
If so how many hours must be taken?		-	240 hrs.	-		
How many hours of drug education are taken in elective units?		5-8 hrs.	6-8 hrs.	2-4 hrs.		20 hrs.
From your handbook nominate the elective units which cover drug education		Health Ed. 241	Health 112 Health Ed. 111	Health & Physical Ed. 110 (Core)	Health	PHR 2200
Are electives which include drug issues taken by the Department of Social Science? If so please nominate			Sociology 221	Social Sc. 110 & 211	Passing ref. only	Passing ref. only
Are electives which include drug issues taken by the Department of Psychology?			Passing ref. only	Passing ref. only	Passing ref. only	Passing ref. only
FUTURE TRENDS IN HEALTH EDUCATION OFFERINGS		Introduction of an interdisciplinary B.Ed. major	More personal issues. Less first aid. More methodology	Introduction of a 30-hr. Health Ed. elective	No change	No change

Note : P.E. and P.H.R. = Physical Education

TABLE 2 - OTHER AVENUES OF PROFESSIONAL DEVELOPMENT FOR HEALTH EDUCATORS

Other than elective study programmes in pre-service teacher education courses, only three avenues are available for the professional development of health educators in Australia. These are :

1. Post Graduate Diploma in Health Education (PG1)

   - Based at Sydney Teachers' College. Inaugurated 1976.
   - One year full-time or equivalent commitment.
   - Entry requirements : Degree (UG1) or Diploma (UG2) and at least one year's successful teaching experience.
   - Availability : No restrictions.

2. Modular In-Service Training Scheme

   - Based at Salisbury College of Advanced Education, Adelaide.
   - One semester of fifteen weeks' full-time commitment.
   - Entry requirements : Teachers' Certificate or Diploma (UG2).
   - Availability : For teachers employed by the South Australian Education Department only. Teachers are bound to return to their school of origin for two years on completion of the course.

3. Associate Diploma in Health Education (UG3)

   - Based at Claremont Teachers' College, Perth. Inaugurated 1975.
   - Two years' full-time or equivalent commitment.
   - Entry requirements : Tertiary Admissions Examination with English, or mature age entry for persons currently engaged in health education.
   - Availability : No restrictions.

6. Health education elective courses are not well patronised by students and there is no demand for additional offerings. Students are aware of the fact that no promotional opportunities exist in health education and they tend to elect to take subjects which enhance their value to future employers.

Table 2 provides information on other avenues of professional development for health educators.

In-service education of teachers is an important means of developing health education personnel. Its value lies partly in the fact that it involves the professional development of experienced teachers. Such persons are more likely to have an awareness of health issues which involve students, and being of mature age their level of commitment is expected to be higher. The most ambitious in-service health education programme is probably held in South Australia where it is a full-time intensive course of thirteen weeks' duration. The Sub-Committee, however, has reservations about the appropriateness of the South Australian scheme for this State. That scheme involves removing classroom teachers from schools for the duration of the programme. A similar scheme in Western Australia would probably run into difficulties because of the need to replace teachers involved in such a programme. Short programmes of a small number of days' or weeks' duration would be unlikely to produce quality health educators; so the Sub-Committee would see merit in mounting a part-time programme of continuous development of teachers in health education over a number of years.

The Education Department of Western Australia conducted considerable in-service programmes for teachers in health education when the primary and secondary syllabuses were being established, and for schools engaged in the Growth and Development programme. However, there has been no recent in-service activity of note in this area.

Attention is drawn to the opportunity for continuing education through the course at Claremont Teachers' College which is shown in Table 2.

RECOMMENDATION 4

The Sub-Committee recommends that further opportunities be made available for the continuing education of teachers of health education in both government and non-government schools.

The Sub-Committee recognises, however, that promotional incentives are likely to influence a teacher's choice of the type of continuing professional development he will undertake, if at all. It remains to be seen whether employing authorities such as the Education Department will be prepared to offer such incentives.

3.02 THE PROFESSIONAL DEVELOPMENT OF HEALTH EDUCATORS

Health educators have limited promotional opportunities in the Education Department of Western Australia. Those working outside Education Departments in Australia often lack stable employment opportunities. In addition there is no centre of academic excellence for the health education profession in Australia, and there is a scarcity of suitable training programmes. It has been suggested that Australia needs a body of professional health educators trained either at overseas institutions or at a centre of excellence in Australia, and the development of a strong professional body of health educators to seek necessary improvements. The Sub-Committee endorses this view.

3.03 EDUCATING OTHER PROFESSIONALS

Education of professional practitioners in addition to health educators in matters pertaining to drugs would be of benefit to the community. Target groups for such programmes would include:

(i) doctors - It has been alleged that many doctors know little about alcoholism and drug dependence. Also the role of the doctor as a dispenser of drugs renders education about drugs essential.

(ii) nurses - This group is heavily involved in administering drugs.

Pre-service programmes in medical and nursing schools would be suitable avenues of education about drugs, but the development of in-service courses for practising professionals is also essential.

3.04 DRUG EDUCATION IN THE COMMUNITY

Targets for community drug education programmes include:

(i) parents - It is important that parents are told why children take drugs, and the need for communication within the family. It would be desirable to include families of children in the education process. In the view of some observers in Eastern Australia, inclusion of the family is difficult to achieve, partly because the presence of their own parents at discussions may inhibit young prople from being completely frank. This view is not supported by the successful results of the Health Education Council's Modern Social Issues programme initiated at Corrigin in Western Australia.

(ii) apprentices and their instructors -

It has been said by observers in other States that apprentices are put under more pressure than other students to take drugs, and have more money to buy them; and that it is necessary for them to know, for instance, how much they can drink before driving. The Sub-Committee does not consider apprentices to be disproportionate users of drugs in this State.

(iii) industrial workers -

Alcoholism is a major cause of lost production in industry aside from the problems faced by the alcoholic and his/her family. The Australian Foundation on Alcoholism and Drug Dependence is involved with an alcoholism in industry programme.

(iv) probation and parole officers -

These officers should be given appropriate training because of their contacts with drug offenders.

(v) police cadets -

A large portion of a policeman's work is spent on crisis intervention.

(vi) the judiciary -

It has been alleged that some of the statements of members of the judiciary in other parts of Australia indicate an ignorance of the effects of drugs.

(vii) the public at large -

Information should be provided to the public concerning drug treatment services which are available.

The general principles of health education programmes which were discussed in Chapter 1 are useful principles also for community education programmes.

3.05 THE INFLUENCE OF THE MASS MEDIA ON DRUG TAKING AND ATTITUDES

Australian studies have shown that the mass media is the most common source of information about all drugs (George, p 5; Health Education Centre, p 3). The Australian experience seems to reflect that of other countries. Smart and Fejer (1974, p 23) pointed out that students in three Canadian cities most frequently chose the news media as the source from which they had learned most about drugs. The same authors referred to a Canadian study of 336 hours of television. In this time there were 295 drug advertisements; most occurred

between 7.00 p.m. and 11.00 p.m. and accounted for 4% of all commercials shown. 43% of drug advertisements were for alcohol, 10% for tobacco and 47% for such other drugs as headache remedies, stomach and cold aids, sedatives and vitamins. Only three items appeared in this period in news broadcasts relating to possible harmful effects of drugs. One dramatic programme portrayed heavy drinking but did not criticize it; only one special 30-minute programme dealt exclusively with drugs; and 13 anti-drug commercials, divided between alcohol and illicit drugs, were shown (Smart and Fejer, 1974, p 34).

Observations which have been made about this role of the mass media include:

- Little is known of the accuracy of knowledge gained (George, p 5)
- The effects of the mass media may be contrary to the objectives of health education (Egger et. al., 1976, p 11), and
- Health educators have no control over the information obtained from this source which may often be misleading and/or use highly persuasive techniques (Smart and Fejer, 1974, p 6).

A New South Wales Report drew attention to the "hidden curriculum" of the mass media in that the contents of programmes and articles often carried a message reinforcing misuse or inducing abuse of drugs (Egger et. al., 1976, p 12). Smart and Fejer (1974, p 5) pointed out that popular television programmes, movies, novels, records and magazines often portray the use of drugs, especially alcohol and marihuana, in highly positive terms.

Cornacchia et. al. (1973, p 40) stated that the mass media spent large sums of money selling drug products to the public; it created a belief structure in which the normal, accepted way to achieve pleasure, health, happiness, relief from life's pains and anxieties, as well as to achieve sexual prowess is to smoke, drink, eat or swallow a drug. A 1969 United States study was quoted by the authors as concluding that there is a relationship between drug use and certain kinds of advertising.

Young (1971, pp 35 - 37) referred to the role of the mass media in amplifying deviant behaviour by the process described below:

> The determining factor in our treatment of individuals is the type of information we receive about them. In modern urban societies there is extreme social segregation between different groups which leads to information being obtained at second hand through the mass media rather than directly by face-to-face contact. The type of information which the mass media portray is that which is "newsworthy". They select events which are *atypical*, present them in a *stereotypical* fashion and contrast them against a backcloth of normality which is *overtypical*...
>
> The twin factors of social segregation and the mass media introduce into the relationship between deviant groups and society an important element of misperception; and the deviancy amplification process is initiated always in terms of, and often because of, incorrect perceptions...
>
> Furthermore, our knowledge of deviants not only is stereotypical because of the distortions of the mass media but is also, unlike in small-scale societies, one-dimensional. For example, we know very little of the methylated-spirits drinker as a person in terms of his attitudes to the world. We know him merely by the label 'meths-drinker' and the hazy stereotype of activities which surrounds this phrase. Rarely - or not at all - have we even seen or talked to him in the early hours of the morning...
>
> The media, then - in a sense - can create social problems, they can present them dramatically and overwhelmingly, and, most important, they can do it suddenly. The media can very quickly and effectively fan public indignation and engineer what one might call "a moral panic" about a certain type of deviancy.

Additional impressions gained from experts in drug education in eastern Australia were that:

- there is little value in the "smoking is a health hazard" statements which followed cigarette advertisements.
- media reports and even warning programmes often tell young people how to prepare and use certain drugs.
- stories about reformed addicts are counter-productive because of the non-verbal message that drug addiction can be easily overcome.
- the media generates public hysteria about young people who use illegal drugs. Reports of drug taking at particular schools can prevent proper communication on the issue at the school; and the school may be "branded", causing resentment by students and suspicion by parents. Such reporting may create a generation or cultural gap between young people and their elders.

It is apparent that a more responsible attitude to drug taking is required of the mass media. Recognizing this, the New South Wales Report referred to earlier in this Section suggested that representations be made to media promoters to alter their current approach, and that public education create a climate of public opinion in which recommended changes would be accepted by commercial interests (Egger et. al.,1976, pp 11-12). In the next Section, it is suggested that a high-level body be established, its functions including encouragement of the mass media to take a more responsible approach where necessary.

RECOMMENDATION 5

That the Sub-Committee confer with the Private Sector Sub-Committee of the Alcohol and Drug Authority with a view to devising means for encouraging a positive health message in the mass media.

3.06 SUGGESTED ADMINISTRATIVE ARRANGEMENTS FOR DRUG PROGRAMMES IN WESTERN AUSTRALIA

The following arrangements are suggested by the Sub-Committee for the furtherance of a positive health programme:

1. A government-community council to advise on drug education policy in a broad sense

It is important that a high level part-time body of experts held in esteem by the community be established to influence policy and activities pertinent to drug education in both the government and private sectors. Members should be experts in the field of drugs in order to be able to make informed statements. Well-meaning administrators without appropriate training and/or knowledge do not provide a satisfactory substitute. Such members would need to be of a calibre that their recommendations were given serious consideration by government bodies, and sufficiently well regarded in the community that neither private nor government organizations could ignore their suggestions without running the risk of public opprobrium. Examples of government organizations with which this body would be concerned could be the Police and Education Departments, whilst a target in the private sector would be the various components of the mass media. Such a body could also provide information of assistance to legislators and to members of the judiciary who deal with drug matters. It is often the case that such bodies which may exist in other places comprise representatives of various sectors of primary (government) and teacher education, the police drug squad and non-government schools. Whilst a spread of community and governmental representation is useful, members of this body should be selected on their merits. Such a body, to be fully effective, would need to be uninhibited by being placed within a bureaucratic structure. The body should not be so large as to inhibit its effective functioning. The secretariat to this body could be provided by a government department, such as the Education or Public Health Departments.

There is at the moment considerable unco-ordinated diversity in the provision of drug education and counselling by both government and private organizations. Whilst the initiative of these diverse bodies should not be discouraged, greater co-ordination is called for to ensure the most effective programme of health education and counselling. Such co-ordination could probably be more effective and lasting if it took the form of voluntary adjustments of all bodies following suitable representation made to them by a respected high-level body.

2. A government inter-departmental committee.

Such a committee could help to co-ordinate overall State Government policy in relation to drugs of all sorts, with feedback being available to the departments involved. This body should be a high-level body and thus be in a position to have some influence on government policy making. It may be appropriate to include representatives from the Commonwealth Government and local government. Departments which could be represented include Public Health, Police, Education and Housing.

3. An Education Department committee on health education.

Unlike the body mentioned in sub-section 1 above, this committee would be concerned with more specific matters such as curriculum development and production of audio-visual materials. It is important that the committee be part of the Education Department so that it may be directly involved in Departmental policy development. However representation from and co-operation with non-government schools would be highly desirable. Consultant groups may be established by this committee to provide specialist assistance where necessary. Such a committee would hopefully co-ordinate all Departmental involvement in health education, and thus obviate fragmentation into areas such as drugs and sex.

4. A senior Education Department official responsible for issuing instructions to schools.

Schools are probably in need of guidance with respect to matters such as what to do if students are found in possession of drugs, what principles should be employed in drug education, and what audio-visual materials should be used or not used. Assistance should be given by an appropriate Departmental official. Proposed questionnaires to schools on drug taking could be vetted by this official.

RECOMMENDATION 6

That the administrative arrangements proposed in sub-sections 1 to 4 of this Section be implemented.

3.07 LEGAL SANCTIONS AGAINST DRUG USE

It appears that the majority of professionals working in drug education and treatment would favour decriminalisation of drug abuse. According to one view, under present punitive legislation many young people found experimenting with marihuana are branded as criminals which causes a further break in communication between them and society in general. As a result of such legislation young people would not talk openly about taking marihuana because they did not know where they stood in relation to the law. All factors should be conducive to gaining access to such youngsters, finding out what problems they may have, and counselling them. At the moment students having drug problems may come into contact with an undesirable world of crime. It is dangerous to view marihuana smokers as emotionally ill: they should be considered as normal as people who take cigarettes and alcohol. Young people see a double standard if their parents who drink alcohol freely do not accept that they can take marihuana. Marihuana is a generation gap identifier. Evidence on its effects to date is far from clear.

Others have argued that whilst it is undesirable to give harsh penalties for marihuana use, yet it is preferable not to legalize yet another drug, and thus give it implicit approval.

The Sub-Committee requests that those involved in the making of laws continue to give open and conscientious consideration to the desirability of legislative prohibitions of drug abuse, bearing in mind the arguments for and against any changes.

The existence of legal prohibitions causes problems for the schools. On one hand it could be argued that schools may have legal and moral responsibilities to report cases of drug taking to law enforcement agencies. On the other hand, some take the "school as a sanctuary" view, according to which drug problems detected in schools are dealt with internally by teachers. Both of these approaches contain a number of problems. In the former case students may not confide in teachers and counsellors for fear of being reported to law enforcement agencies. The latter view also has its shortcomings because in a number of drug cases, people outside the school should be involved, for example parents. The proposed memorandum to school principals set out in Appendix 4 outlines the Sub-Committee's approach to this dilemma.

APPENDIX 1 - ORGANISATIONS APPROACHED

Representatives of the following organisations were contacted for the purpose of obtaining information for this Report :

Organisation	Persons Contacted
Alcohol and Drug Addicts Treatment Board, South Australia	Dr C Alexander
Alcoholics and Drug Dependent Persons Services, Victoria	Mr P Billings
Australasian Division of Seventh Day Adventists	Pastor R Taylor
Australian Foundation on Alcoholism and Drug Dependence	Mr P Stolz
Canberra College of Advanced Education	Dr R Irwin
Capital Territory Health Commission	Miss J Grimsley Mr G van der Heide
Catholic Education Commission, Western Australia	Mrs R Tang
Christian Welfare Centre of the Churches of Christ, Western Australia	Miss J Cook Mr D Hale
Churchlands Teachers' College	Dr D Harvey
Claremont Teachers' College	Mr T Walmsley
Curriculum Development Centre	Mr H Townsend
Department for Community Welfare, Western Australia	Mr H Bloom
Department of Education (Commonwealth)	Dr F Grotowski
Department of Health (Commonwealth)	Dr L Drew Mrs J Nolan Ms K Roger
Department of Health, Victoria	Dr D Rankin Mr A Watts
Department of Public Health, South Australia	Mr M Drake Dr C Fuller
Department of Public Health, Western Australia	Sr M Clarke
Education Department of South Australia	Mrs M de Zwart Mrs V Edwards Mr R Henderson Mrs S Hodgetts Miss A Ragless Mr N Wardrop
Education Department of Victoria	Mr N Bavington
Education Department of Western Australia	Mrs L Ellis Mr L Louden Miss V Mayger Mr J Sully

Organisation	Persons Contacted
Foundation for Research and Treatment of Alcoholism and Drug Dependence	Mrs N Synge
Graylands Teachers' College	Miss C Slater
Health Commission of New South Wales	Mr S Chapman Dr R Webb
Health Education Council of Western Australia	Mrs J Bunbury
Loreto Convent, Claremont, Western Australia	Mrs A Nicholls
Mental Health Services, Western Australia	Ms A Macnab
Mount Lawley Teachers' College	Miss M Carroll
New South Wales Department of Education	Mrs A Ashley Riddle Miss E Guthrie
Presbyterian Ladies' College, Western Australia	Mrs R Gard
Royal Australian College of General Practitioners, Western Australia	Dr F Mansfield
Salisbury College of Advanced Education	Mr J Nicholas
Seventh Day Adventist Conference, Western Australia	Pastor W Dowling
Unattached	Mr O Hicks
University of Western Australia	Dr E Csillag Mr R Flecker Dr R Mackie
Victorian Foundation on Alcoholism and Drug Dependence	Mr D Travers
Victorian Temperance Alliance	Rev. B Moxon
Western Australian Alcohol and Drug Authority	Mr J Brooksbank
Western Australian Institute of Techology	Mr J Winfield
Western Australian Secondary Teachers' College	Mr M Walker

APPENDIX 2 - SURVEYS OF DRUG USE BY STUDENTS IN AUSTRALIA

Below is a series of extracts from surveys or summaries thereof. Surveys are those specifically directed at drug use by students. Surveys of the populace in general may be relevant but have not been included here.

Australian Capital Territory

"Alcohol was found to be the drug most frequently used by boys in both 1973 and 1974 and girls in 1974. In 1973, the minor analgesics were the drug group most often used by the girls ...

In 1973, 63.2% of the sample were not multiple drug users while in 1974 the percentage increased to 65.6%."

Source: "National Drug Education Programme Research Project", 1975, pp 4 - 5.

New South Wales

" ... from 1971 to 1973 the fourth form, sixth form and trade course samples steadily increased their use of marihuana. The proportion of respondents who reported that their friends used marihuana provides another index of prevalence, and Table 8 shows an increase for the fourth form, sixth form and trade courses parallel to the increase in self use shown in Table 7. The general nurses in 1973 also reported that an increasedproportion of their friends used marihuana, but this was not accompanied by a significantly higher level of reported self use, suggesting that in 1973 the users among the nurses were more open about the practice."

Source: Champion, 1976, p 33.

"In each year [1971 to 1973] the data are based on the replies of more than 7 000 respondents, of whom over 5 000 were high school students. Alcohol and analgesics were almost universally used by all groups and tobacco was also used extensively. In general alcohol use seemed to be increasing, despite the fact that it was close to saturation point, but the use of tobacco and analgesics was relatively static. The attitudes towards tobacco were becoming less permissive, which may have been a result of health education, but without the hoped for effect on use.

Marihuana showed the most dramatic changes for any drug with an increase of use by several groups, increasingly permissive attitudes and a reduced perception of danger. Approximately half of the marihuana users also used at least one other illicit substance and in general they were heavier users of licit drugs than the non-users. Only a small proportion of users in the sensitive groups used the drug frequently, but among the risk groups almost a quarter were weekly users.

In general among the sensitive groups the use of stimulants declined together with a reduction in permissiveness. This contrasts with the increased permissiveness towards hallucinogens and the reduced perception of danger from their use, suggesting that the changes in attitudes towards the stimulants were not likely to have resulted from health education, which has been directed towards both areas. Conceivably the underground message 'speed kills' has had an effect, not only on attitudes but also on use. The use of hallucinogens has not decreased.

The use of narcotics has remained relatively static in most groups even though some groups showed an increase in permissiveness and a decline in the perception of danger. This may have ill portents for the future."

Source: Bell et. al., 1975, pp 2 - 3.

"By age 11 almost one in two boys and one in three girls have tasted alcohol. By age 15 there are only 9 per cent of boys and 10 per cent of girls who have never tasted alcohol.

Family members (particularly father/stepfather) are the source of the first drink for almost 60 per cent of young people. There is also a significant percentage of males (17%) who claim to have helped themselves to their first drink ...

From a series of measures used in the questionnaire, about 2 per cent of the sample were defined as problem drinkers, i.e. those whose lives appear to be already affected by the over-use of alcohol. A further 16 per cent were classed as possible or potential problem drinkers ...

A high correlation exists between drinking and smoking amongst adolescents, in terms of age of onset and extent of both behaviours. 43 per cent of those in the sample who have tasted their first drink before age 11 have also had their first smoke before 11. They also spend more on tobacco and drink more in later adolescence. On the other hand, 69 per cent of non-drinkers have never smoked ...

It is apparent that peer pressures for the older adolescent are a major influence on the extent of drinking. A significantly higher percentage of regular drinkers than irregular drinkers claim to feel 'left out' if they do not have a drink at a social gathering. Twice as many regular drinkers as irregular and non-drinkers also claim to have friends who urge them to drink; more of the former say they do not mind this. Up to 30 per cent of irregular drinkers admit that friends'urging either worries them or makes them angry, whereas only 5 per cent of drinkers claim this."

Source: Egger et. al., 1976, pp 7 - 9.

Queensland

"The percentage of students who have at least tasted alcohol increases from 68.9% at grade six to 96.0% at grade twelve. In addition to greater use of alcohol, older students have had more opportunities to take alcohol than have the younger students, more of their friends drink and they express a

greater willingness to accept a drink if offered. While one third of grade six pupils believe alcohol to be very dangerous to their health, only 2.7% of grade twelve students believe this to be so ...

After alcohol, cannabis is the next most popular substance in the high school years. A total of 17.6% of grade twelve students have used cannabis. An average of 6.5% of all students have used inhalants at some time. This percentage of inhalant users is consistent across grades. Inhalants are definitely the most widely accepted drug type among the younger students. Young students believe inhalants to be less dangerous than other drugs, express more willingness to use inhalants if offered, and see future personal use of inhalants as more of a possibility than for any other drug ...

The most commonly used combinations are alcohol plus inhalants for younger students, and alcohol plus cannabis for those at high school. Their use or non-use of alcohol aside, students who use only one type of drug tend to be occasional rather than regular users. Multiple drug users are more often regular users."

Source: "Alcohol and Drug Use by Queensland School Children...", pp 1 - 4.

"... it is immediately obvious that a decisive role is played by the peer group of a Queensland school student ...

... drug users tend to believe that alcohol and illicit drugs are less dangerous to health than do non-users ...

... parents of drug taking students approve of alcohol more and serve beer or wine more often with meals than parents of non-drug users ...

It would seem that parents, by example, create in their children an attitude towards the use of pharmacological substances in general, rather than towards specific substances.

However ... parental influence is less important than peer group influence."

Source: "Children, Drugs and Alcohol...", 1976, p 1.

South Australia

"The percentage of students reporting having used drugs at some time were: alcohol, 85%; minor painkillers, 81%; tobacco, 72%; sedatives, 24%; stimulants, 15%; tranquillisers, 14%; marihuana, 13%; narcotics, 4%; and hallucinogens, 4%. Male students were significantly more likely to report having used alcohol and tobacco, while females were more likely to have reported having used stimulants. Marihuana use by male and female students appears to be very similar. In general, there appears to be little difference in reported drug use by different age groups, except in the case of marihuana which steadily increases in reported use with age, being only 4% among students under 15 years of age and increasing to over 34% among students over the age of 17 ...

... while there did not in 1974 appear to be widespread abuse of alcohol among our relatively small sample of Adelaide high school students, there was a small group of students (roughly 7%) about whom we should be concerned."

Source: Rigby, pp 1 - 2.

Victoria

"It is quite clear from the results that in Melbourne the rates of drug use by young people are lower than those reported in other countries where similar surveys have been carried out ...

Although the younger group (15-16) generally uses drugs less than the older group (17-21), the use of narcotics is higher in the younger group. Alcohol is the drug most commonly used, and among secondary students this was highest among apprentices. Male students at both secondary and tertiary levels drink more often and more heavily than female students."

Source: Health Education Centre, p 1.

"The use of alcohol increased with age, and the Ballarat rates would appear to be higher than the Melbourne ones two years earlier. However, the most disturbing feature is the fact that over 7% of third formers were classified as heavy or very heavy drinkers, comparable rates were 10% in secondary and 13% for tertiary, i.e. they reported having ten or more drinks on drinking days.

One in two secondary school children reported that they smoked with one in five smoking 5 or more cigarettes daily. A striking feature is the consistency of the rates reported, i.e. similar smoking behaviour was reported in Forms 3 and 5 in Ballarat and in Form 5 in Melbourne. Fewer tertiary students smoked (two thirds were non-smokers) but those who did smoked more heavily than their secondary counterparts (over 11% of tertiary students in Ballarat smoked 15 or more cigarettes daily, as compared with 3% of secondary students).

Marijuana was the most commonly reported drug used and it had been used on at least one occasion by over 2% of Form 3 students and by nearly 12% of those in Form 5, a rate higher than that reported for Melbourne ...

Heavy drinking is associated with both smoking and illicit drug use. Whereas only 11% of the non-drinkers smoked, this was true of two-thirds of the moderate to very heavy drinkers. Use of illicit drugs on five or more occasions progressed in Ballarat from 2.3% among non-drinkers to 39.3% among very heavy drinkers. This pattern was more pronounced in Ballarat than in Melbourne. Illicit drug use increased also with nicotine consumption with only 6% of non-smokers reporting use of illicit drugs on five or more occasions as compared with 38.5% of those smoking 25 or more cigarettes daily."

Source: "Drug Use by the Young Population of Ballarat", pp 2 - 3.

Western Australia

"A total of 129 illicit drug-takers and 115 non-drug-taking controls in the under thirty age group were interviewed ... using a detailed questionnaire of ninety-one items and results for the two groups were compared ...

There was a mean of 3.55 drugs per subject tried or used; 47 (36.4%) had used four drugs or more. However, 33 (25.6%) had never used any other drug besides cannabis.

The frequency of drug-taking was disturbingly high, 51.2% of the total admitting to use of some kind of drug several times weekly or more. This habit was strongest in the multiple drug users; frequency was lowest in the cannabis only subjects - only 6 admitted to using the drug once weekly or more."

Source: "Perth Survey Among the Under Thirty Age Group," 1975, pp 15 - 17.

APPENDIX 3 - HEALTH EDUCATION COUNCIL OF WESTERN AUSTRALIA

DRUG EDUCATION PROGRAMME, JULY, 1975 TO MARCH, 1976

General

Policy Drug abuse belongs in a social spectrum and should not be isolated, educationally, from other issues. Education in these issues should be developed within communities and involve all age and social groups, within the limits of staff resources. Propaganda on drugs should be limited to information on educational resources available. Horror propaganda, and the vilifying of parents and children involved in drug activity, or suspected of such, is rejected as destructive. The Council should support the role of law enforcement and treatment agencies.

The Drug Scene in Western Australia Impressions of Health Education Council staff in close contact with groups are as follows:

(a) It is still true that the main dependency problem is in the 35+ age group, with central nervous system stimulants and depressors.

(b) Experimentation by young people continues. There is a need for research in this area, to monitor changes in attitudes as well as the drug groups involved.

(c) There has been increased activity in three criminal areas: drug smuggling, drug pushing and armed assault and robbery by drug addicts. This latter has been recognised elsewhere as a forerunner of a serious illicit drug situation.

(d) Cannabis and L.S.D. are still freely available.

These impressions have been confirmed by senior police drug squad officers.

Field Work

The following work has been carred out by Health Education Council staff during the period:

Modern Social Issues Programmes

Completed in the period	38
Current	4
Committed for 1976/77	14

(These figures do not include work in Schools of Nursing)

This programme places special emphasis on the drug issue but is not confined to drugs. Demand has shifted from community groups to schools. Primary schools now request this programme in about equal numbers with high schools.

Drug Discussion Series

Completed in the period 2

This 4 - session programme was designed for people who want to make a deeper examination of the drug issue than is possible in a single talk, but who did not want to cover the wider range of issues. Demand has dropped, but continues at a lower level for parent/youth meetings.

Nursing Education

Schools of Nursing

Completed in the period 11

Sessions (@ 2 hours each) 404

These figures are for social issues and health education methodology. It is significant that many nurses living in country districts come forward as volunteers in local programmes. They are aware of the nature and purpose of modern social issues discussion and make skilful discussion leaders.

College of Nursing (W.A.I.T.)

Completed in the period 1

Sessions (@ 1½ hours each) 10

Comment

The content of the programmes in the nursing schools has not changed much during the period although there has been a marked change in emphasis.

The methods used have had to be modified as students are more sophisticated in certain areas (e.g. drugs). However although the students are better informed most of them still need to be given the opportunity to discuss these issues in the light of experience gained since leaving school. In the near future attention will need to be given to future requirements in nursing schools. If our programmes with the nursing education students at the College are successful then the nurse educators in the future will want to conduct their own programmes. The Council's role must shift to that of resource personnel as is the case in other areas.

Information Service

The Council has continued with Information Bulletins, newspaper and other media services and the provision of technical resource materials such as books and journals. A student project in drugs for the human biology course was produced and is widely used.

Film Discussion Guides

The Commonwealth films Where Are We Heading, The Choice, The Road To Charlie, Maybe Tomorrow and Drugs and the Law are still widely used.

To help local workers and group leaders make more effective use of films, discussion booklets have been prepared for the first three listed.
Guides for the other two are in preparation.

The guides are sent out as soon as requests are received, to permit study and planning before the film arrives. There is some evidence that teachers find the guides very helpful.

Talks

A total of 88 single talks on the drug issue were given to service clubs, parent groups, youth groups, etc. These talks are designed to outline the drug issue and explain the services available to groups for a deeper examination of the problem.

Auxiliary Workers' Programme

The training of skilled volunteers for use as discussion leaders (auxiliary workers) continues, in association with Mental Health Services, Good Neighbour Council, Australian Red Cross and a changing group of Church offices. All these agencies are involved in drug education in various ways. The auxiliaries have continued to contribute decisively to field work, at group and person-to-person levels, without cost to the community.

Information Centre

A centre to which anxious parents and others may come for discussion of drug-centred behaviour by relatives and friends has continued. It is expected that this activity will be expanded as new premises are renovated and equipped. A total of 30 interviews were conducted by staff officers and trained auxiliaries.

Teacher Training Colleges

Six health education programmes at Churchlands, Mount Lawley and Graylands teachers' colleges have been conducted, with drugs a major issue examined in the courses.

Resources Development

The Council now has adequate equipment for the production of video tapes, discussion films, slides, cassettes and printed matter for use by locally-based health workers and community groups. Drugs will be a major area for materials production. One super 8mm film The Brain is completed, for use with audio cassette. Field trial of the film is currently in train. All materials produced will be available to other States and Commonwealth agencies.

APPENDIX 4 - PROPOSED MEMORANDUM TO PRINCIPALS

RE : DRUG USE AT SCHOOLS

There appears to be some uncertainty as to how a principal or teacher should react to cases of drug use in schools. The following suggestions may be useful. Principals should use this document for their own guidance; relevant parts should be brought to the attention of teachers, but its contents should not be publicised indiscriminately.

Legal duties with regard to illicit drugs

1. Legal advice indicates that a teacher who becomes aware of illegal drug taking and who does not report this to the police IS NOT COMMITTING AN OFFENCE. This is true in cases of experimentation with drugs or even with drug pushing (a). Teachers may recognize a moral obligation to report to the police in some cases, for example drug pushing. However there is not a legal obligation to do so.

2. A police officer has the right to enter a school either to make an arrest or to search for narcotics. Although it is expected that the school principal will be informed beforehand of any such incursion by the police this is not necessary. Hindering a police officer in the execution of these duties is an offence.

3. NO person is under an obligation to answer police questions other than to provide his name and address. Even an arrested person has a right to refuse to answer questions.

4. In the context of drug use, the only case where a person would be required to answer questions about illegal drugs is when giving evidence in a court of law. Confidential information given to a teacher, guidance officer or other member of the school staff is not privileged information in court and must be divulged upon request when evidence is being given in court.

5. It can be seen from the above that the teacher or other school personnel have a wide latitude to maintain confidentiality. In some cases, however, they might feel an implied obligation to pass on confidential information.

Other points

6. Schools conducting or contemplating drug education programmes could obtain valuable information from the principles set out in Chapter 1 of this Report.

7. A number of schools have asked guest speakers to speak to students on matters involving drugs. Choice of outside speakers and the conduct of such functions should be consistent with the principles referred to in 6 above. Outside speakers should be a part of an integrated programme of health education at the school. The role of the teacher as being responsible for the education and pastoral care of students should not be abrogated in favour of occasional speakers.

(a) A distinction has been made between pushing, distributing and consuming illegal drugs. Both the pusher and the distributor actually sell drugs, although the distributor operates on a smaller scale than the pusher. Under the Police Act, 1892 - 1974 heavier penalties apply for the sale of drugs and for possession with intent to sell, than for mere possession.

8. Decisions about the purchase of teaching aids concerning drugs are of tremendous importance because some audio-visual material can actually be counter-productive, even to the extent of encouraging experimentation with drugs. Advice on the purchase of teaching aids may be obtained from the Teaching Aids Advisory Service at the Education Department's Curriculum Branch. Advice is available to government and non-government schools.

9. Legal enforcement may not be a long term solution to the drug problem. Students with drug problems should be encouraged to seek counselling. A list of available counselling services is contained in Chapter 2 of this Report.

10. Breaking the trust of students who give confidential information may shut off communication when it is vitally needed. Teachers or guidance officers should advise the principal of matters pertaining to drug taking but in such situations the principal should see himself as a counsellor rather than as an enforcer of the rules. The principal may feel that the welfare of the student requires that his parents be informed. The principal should use his own discretion in making such decisions; but he may wish to discuss the matter with the Director of Schools, Education Department of Western Australia, or his representative.

11. The principal should certainly avoid sending home circulars to parents or advising representatives of the mass media about alleged cases of drug taking. Such action could precipitate hysteria and break down meaningful communication between students, teachers and parents.

12. If a pupil is being treated for drug abuse, the success of the treatment depends to a large extent on the student maintaining a normal life. There should not be any impediment to the student's maintaining a normal school course. Suspension or expulsion of students for drug taking should be avoided. Often drug taking is only experimentation. Suspension or expulsion may make martyrs of the students affected and thus be counter-productive.

13. If for any reason a principal feels it necessary to question the contents of a student's belongings it is desirable to ask the student concerned to reveal such contents.

Smoking at schools

14. Attention is drawn to Section 4.04 of The Teachers' Handbook and Administrative Instructions (Education Department of Western Australia) which states that smoking is forbidden on school premises, except the staffroom, at any time. Teachers should be aware that the example they give to students by smoking or not smoking may have a more potent effect on students' attitudes to smoking than any health education programme.

Alcohol at schools

15. Attention is drawn to Regulation 49 (6) of the Education Department of Western Australia which states that in no circumstances shall intoxicating liquor be brought onto the premises or grounds of any school.

Medicines

16. In cases where a student is required to take a particular drug for medicinal purposes, a letter to that effect should be sent to the school by the parent. Authority may then be delegated to a member of the school staff to administer the drug.

17. If a member of the school staff notices that a student is regularly taking non-prescribed drugs supposedly for medicinal reasons, the doctor or nurse allocated to the school should be informed.

18. In exceptional cases a member of the school staff may find it necessary to administer a minor analgesic such as aspirin. In such cases, it is desirable that a record be kept. Regular dispensation of such drugs to particular students should be avoided.

Further Advice

19. Useful additional information may be obtained from Appendix E to The Teachers' Handbook and Administrative Instructions which refers to the removal of students from school by police officers.

20. If a member of the staff is in any doubt about procedures which should be adopted in matters involving drugs, the principal may seek advice from the Director of Schools.

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